SOUTHERN WEST VIRGINIA
ORAL & MAXILLOFACIAL SURGEONS, LTD

Lewis D. Gilbert, DDS

REFERRAL FORM

Email to info@smilewv.com
or Fax to 304-872-5999

PATIENT

Name: _____ **DOB:** _____/_____/_____

Address (Including City, State ZIP)**:** _____Home Phone:_____

Alt. Phone: _____ **Email:** _____

Guardian (*if under 18*): _____ **Relationship:** _____ ☐ **N/A**

Health Issues and/or Medications: _____

_____

PAYMENT PREFERENCE ☐ **Insurance:** _____ ☐ **Private Pay** ☐ **Other:** _____

PANOREX *Please note pano must be less than one (1) year old.

☐ **Patient Bringing*** ☐ **Emailed/Mailed***

☐ **New Pano Needed**

CONSULTATION/PROCEDURE

☐ **Dental Implant(s)** ☐ **Dento-Alveolar**

☐ **Extraction(s)** ☐ **Expose/Ligate**

☐ **Wisdom Teeth** ☐ **Facial Trauma**

☐ **Pathology** ☐ **Frenectomy**

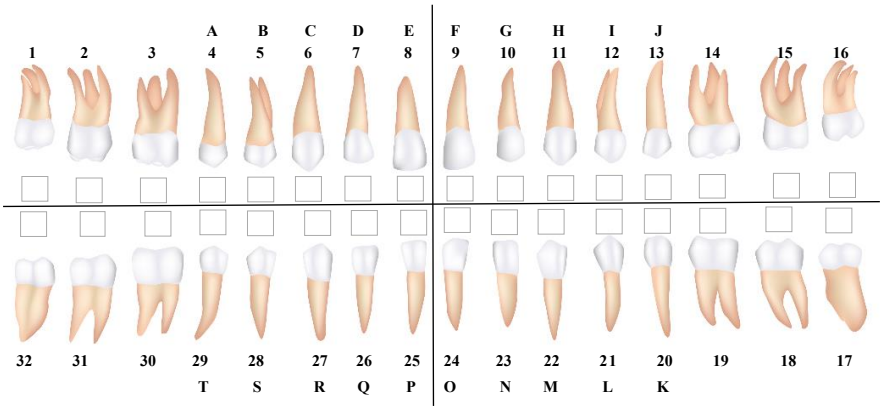
☐ **Other/Notes:** _____

_____

_____

TREATMENT AREAS

Please mark each area to be evaluated.



REFERRING OFFICE

Referring Physician: _____ **Date:** _____/_____/_____

Phone: _____ **Fax:** _____ **Email:** _____

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